IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

MARC BOWMAN,

Plaintiff, No. CIV S- 04-0986 DFL CMK

vs.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Defendant. FINDINGS & RECOMMENDATIONS

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Plaintiff, Marc Bowman, brings this action pursuant to 42 U.S.C. § 405(g), seeking judicial review of a final decision of the Commissioner of Social Security ("Commissioner") denying his application for disability insurance benefits (" DIB") under the provisions of Title II of the Social Security Act.[1] The parties have filed cross motions for summary judgment. For the reasons discussed below, the court recommends plaintiff's motion for summary judgment or remand be denied and the Commissioner's cross motion for summary judgment be granted.

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[1]On May 19, 2004, this action was transferred intradistrict from the Fresno division pursuant to Local Rule 3-120(b).

I. Background

Plaintiff filed an application for DIB on September 7, 2000, alleging an inability to work since February 1998 due to a disabling condition, which involved among other things, fatigue, pain, headaches, eye pain, dizziness and mental disorders. (Tr. 97-98, 131.) Plaintiff's application was denied initially and upon reconsideration. A hearing was held before an administrative law judge ("ALJ") on May 14, 2002. (Tr. 18-59.) Plaintiff was advised of his right to representation and waived it, choosing to proceed pro se. (Tr. 20-25.) At the hearing, both plaintiff and his mother testified. (Tr. 18-59.)

At the hearing, plaintiff testified that he was born on October 9, 1960 and had a high school education. (Tr. 42.) His employment history includes working in real estate sales and working as a logger. (Tr. 42-43.) Plaintiff stated that he had his own logging business and also had experience in being a heavy equipment operator. (Tr. 43-44.) After 1987, besides logging and operating heavy machinery, the only work plaintiff engaged in was his real estate investments. (Tr. 44-45.) Plaintiff stated that he had real estate investments, which consisted of buying and developing land with equipment. (Tr. 45.) Plaintiff stated that he harvested timber on his own real estate and other people's properties. (Tr. 45.) Since his illness began, plaintiff has been supporting himself by selling real estate for less than value through sales arranged by his mother. (Tr. 45.)

Plaintiff testified that, on February 15, 1998, he became ill with what he believed was the flu because he had a fever, was coughing large amounts of mucus, and had other flu-like symptoms. (Tr. 45-46.) In April of 1998, plaintiff went to the Century Wellness Center in Reno, Nevada and was seen by Dr. Kerr. (Tr. 46.) Plaintiff states that he has misplaced his records from Dr. Kerr. (Tr. 46.)

Plaintiff testified that since 1998, he has had periods of some improvement. (Tr. 45.) Plaintiff stated that "there has always been something plagu[ing] him and that, since 1998, he has never felt better than a 'five' on a scale of one to ten." (Tr. 45.) Plaintiff stated that, on

average, he felt like a two. (Tr. 47.) Plaintiff described symptoms, beginning in August or September 1998, of being increasingly weak and growing congestion in his lungs. (Tr. 48.) He experienced weight loss, unbelievable fatigue, diarrhea or constipation, pain, extreme pain and "fibromyalgic" type symptoms. (Tr. 48.) Sometime between August 1998 and October 1998, and perhaps prior to a week-long visit to Sutter Center for Psychiatry, plaintiff experienced night sweats, chills, extreme fear, essentially a [p]anic disorder that escalated into panic attacks about three times." (Tr. 51.) At that time, plaintiff stated that he was at a very low point and that the doctor told him that his "mind did something to [his] body, and shut the capillaries off and [he] lost feeling and circulation in [his] extremities." (Tr. 51.) That episode lasted for about three weeks and culminated in plaintiff going to the hospital. (Tr. 52.) At the hospital, plaintiff was given a pill, which helped considerably, but his fatigue and pain were still severe. (Tr. 52.) Plaintiff reported that his constant head and eye aches were helped tremendously and ceased to a certain extent after he underwent sinus surgery in March 2002. (Tr. 48-50, 52.) Plaintiff stated that, since his sinus surgery, he feels better and has more energy.

From 1998 until plaintiff had his sinus surgery in 2002, his daily activities included spending a lot of time seeing health care professionals and trying many different therapies. (Tr. 53.) During the day, he sometimes sat outside in the sun or the shade. (Tr. 53.) Plaintiff walked sometimes and had massage therapy. (Tr. 53.) He testified that he also watched lots of television, and, if he felt better, he took rides in his pickup truck. (Tr. 53.) Plaintiff stated he would drive to a property which he owned to watch the ducks. (Tr. 53.) He also played cards and played blackjack with himself. During this period, plaintiff lived with his mother. (Tr. 53.) Plaintiff testified that his mother took care of him; doing all the household chores and shopping. (Tr. 53.)

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Plaintiff's mother, Georgia Bowman, testified at the hearing that plaintiff had a good reputation and was an excellent real estate salesman and very skilled at running heavy equipment. (Tr. 55.) Ms. Bowman stated that plaintiff's illness had put them in a financial bind and that, as a result, she was selling her house. (Tr. 55.)

The record does not contain any treating physician source opinions nor any relevant consultative examining source opinions. (Tr. 4-5.) [2] Four state agency reviewing physicians, Marshall Gollub, M.D., Francy Mateus, M.D., David Pong, M.D., and Irwin Lyons, M.D., opined that the medical evidence of record was insufficient to diagnose any impairment prior to December 31, 1999, plaintiff's last insured date. (Tr. 60-61, 252, 270.)

In a decision dated August 28, 2002, the ALJ found that plaintiff was not disabled. The basis for the ALJ's decision was his finding that there was insufficient evidence to establish that plaintiff had any impairments or combination of impairments that limited his ability to work on or prior to December 31, 1999. (Tr. 16-17.) The ALJ's decision became the final decision of the Commissioner when the Appeals Council denied plaintiff's request for review on March 18, 2003. (Tr. 6.) Plaintiff filed a timely appeal on May 6, 2003.

II. Standard of Review

This court's review is limited to whether the Commissioner's decision to deny benefits to plaintiff is based on proper legal standards under 42 U.S.C. § 405(g) and supported by substantial evidence on the record as a whole. See Copeland v. Bowen, 861 F.2d 536, 538 (9th Cir. 1988) (citing Desrosiers v. Secretary of Health and Human Services, 846 F.2d 573, 575-76 (9th Cir. 1988)). Substantial evidence means more than a mere scintilla of evidence, but

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[2]The record does contain a 2001 consultative internal medicine examining opinion (Tr. 443-448) and a 2001 consultative psychiatric examining opinion (Tr. 438-442.) However, those opinions are not relevant because neither assess plaintiff's alleged limitations or impairments for the period at issue—between plaintiff's onset date of disability, February 15, 1998, and the date he was last insured, December 31, 1999. To be entitled to disability insurance benefits, plaintiff must establish that he became disabled on or before December 31, 1999. See Tidwell v. Apfel, 161 F.3d 599, 601 (9th Cir. 1999) (stating that Title II claimant must establish disability by date last insured).

less than a preponderance, Saelee v. Chater, 94 F.3d 520, 521 (9th Cir. 1996) (citing Sorensen v. Weinberger, 514 F.2d 1112, 1119 n.10 (9th Cir. 1975)). "It means such evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 402, 91 S. Ct. 1420 (1971) (quoting Consolidated Edison Co. v. N.L.R.B., 305 U.S. 197, 229, 59 S. Ct. 206 (1938)). The court must consider both evidence that supports and evidence that detracts from the Commissioner's decision, but the denial of benefits shall not be overturned even if there is enough evidence in the record to support a contrary decision. See Jones v. Heckler, 760 F.2d 993, 995 (9th Cir. 1985). If substantial evidence supports the administrative findings, or if there is conflicting evidence supporting a finding of either disability or nondisability, the finding of the ALJ is conclusive, see Sprague v. Bowen, 812 F.2d 1226, 1229-30 (9th Cir. 1987), and may be set aside only if an improper legal standard was applied in weighing the evidence. See Burkhart v. Bowen, 856 F.2d 1335, 1338 (9th Cir. 1988).

III. Discussion

As an initial matter, the undersigned notes that plaintiff has presented additional evidence outside the administrative record. He submitted several letters from friends with his November 16, 2004 motion for summary judgment and presented supplemental evidence on May 2, 2005. The supplemental evidence presented on May 2, 2005 consists of two declarations, which describe plaintiff's ill health and consumption of medicine. The Commissioner has objected to both of plaintiff's offers of evidence outside the administrative record.

Pursuant to Section 205(g) of the Social Security Act, 42 U.S.C. § 405(g), the record in a DIB review is limited to the copy of the certified transcript of the administrative record that is filed with the defendant's answer and to additional evidence that is new and material. In order for additional evidence to be new and material, there must be a reasonable probability that the additional evidence would have changed the ALJ's decision. See Booz v. Sec. of HHS, 734 F.2d 1378, 1380-81 (9th Cir. 1984). There is not a reasonable probability that

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plaintiff's additional evidence would have changed the ALJ's decision. Accordingly, the undersigned declines to consider plaintiff's additional evidence and limits his review solely to the certified administrative transcript.

Plaintiff contends that "he was NOT provided in this case with 'sympathetic assistance' by either the Social Security Administration or the Administrative Law Judge..." (Pl.'s Mot. Summ. J. (doc. 32) at ¶ 5 (emphasis in original.)) In support of his contention, plaintiff states that, when a claimant proceeds pro se, the Social Security Administration and the ALJ owe him a heightened duty to fully develop the record and provide sympathetic assistance.

In Social Security cases, the ALJ has a special duty to fully and fairly develop the record to assure that the claimant's interests are protected. See Brown v. Heckler, 713 F.2d 441, 443 (9th Cir. 1983). When a claimant appears pro se, the ALJ must "scrupulously and conscientiously probe into, inquire of, and explore all the relevant facts." Key v. Heckler, 754 F.2d 1545, 1551 (9th Cir. 1985). The absence of counsel does not "affect the validity of the hearing and hence warrant remand, unless the claimant can demonstrate prejudice or unfairness in the administrative proceedings." Vidal v. Harris, 637 F.2d 710, 713 (9th Cir. 1981.) The ALJ can fulfill his or her duty to the pro se claimant by making a reasonable effort to obtain medical evidence from the claimant's treating sources, or by ordering a consultative examination when the medical evidence is incomplete or unclear. See 42 U.S.C. § 423(d)(5)(A).

Here, the ALJ fulfilled his obligation to develop the record. The ALJ questioned plaintiff's decision to proceed without an attorney, and he explained options that plaintiff had for obtaining an attorney at no cost. (Tr. 20-24.) Upon questioning, plaintiff stated that he wanted to proceed representing himself. (Tr. 24.) Throughout the hearing, the ALJ inquired of plaintiff in a neutral manner. The ALJ also spent significant time going over medical records with plaintiff to find out what plaintiff had brought to the hearing. The ALJ advised plaintiff to send in other medical records. (Tr. 29-35.). The ALJ offered to have his office request the records, but plaintiff opted to provide the records himself. (Tr. 36.) The record reveals that various medical

records were provided, although none were from a treating physician and that there are records of two relevant state agency consultative examinations. (Tr. 199-257.) The ALJ also gave plaintiff several opportunities to further develop answers and repeatedly had to remind plaintiff to describe the problems plaintiff was having instead of what plaintiff believed to be his diagnosis to be. (Tr. 51.) Based on this, the undersigned finds that the ALJ fulfilled his duty to develop the record.

Next, plaintiff argues that there was an "improper assessment of the medical records." (Pl.'s Mot. Summ. J. (doc. 32) at ¶ 6.) Although plaintiff cites the standard for weighing competing medical source opinions, plaintiff fails to identify any instance in which the ALJ improperly assessed the medical evidence of record. The record instead reveals that the ALJ noted that the only relevant medical opinion in the record was the assessment of a state agency physician who concluded that there was insufficient evidence to establish a diagnosis on or prior to December 31, 1999. (Tr. 16, 257-270.) As there was only one relevant medical opinion in the record,[3] the ALJ could not have improperly weighed competing opinions. Accordingly, the undersigned finds that the ALJ did not err in assessing the medical evidence.

Next, plaintiff contends that "[m]edical evidence, especially uncontradicted evidence, must be viewed by the Secretary in the light most favorable to claimant." (Pl.'s Mot. Summ. J. (doc. 32) at ¶ 7.) Plaintiff cites several cases, all but one from other jurisdictions, to support his contention. The Ninth Circuit case cited by plaintiff, Hammock v. Bowen, 867 F.2d 1209 (9th Cir. 1989) was amended and superceded by Hammock v. Bowen, 879 F.2d 498 (9th Cir. 1989), and it does not support plaintiff's proposition. A review of the cases cited by plaintiff reveals that plaintiff most likely has misconstrued the standard which states that the opinion of a treating physician may be disregarded only for clear and convincing evidence.

[3]Much of the medial evidence provided by plaintiff consists of lists of physicians, lists of prescriptions, lists of alternative medical providers, or pictures of plaintiff's various medications, but it does not contain any diagnoses or physician's reports. (Tr. 213-214, 219, 224.)

Additionally, a review of the record does not reveal that plaintiff has introduced uncontradicted evidence of a physician's opinion of any disability or limitation for the relevant period between 1998 and December 31, 1999, which is the date that plaintiff was last insured. As plaintiff has not submitted a relevant opinion from a treating physician, the undersigned rejects plaintiff's third claim of error.

Plaintiff's final claim is that he was diagnosed with Chronic Fatigue Syndrome which is a medically determinable impairment that can be the basis for a finding of disability. (Pl.'s Mot. Summ. J. (doc. 32) at ¶ 8.) Plaintiff bears the burden of proof at the second step of the five-step sequential evaluation to establish that any alleged impairments, alone or in combination, are severe. See Bowen v. Yuckert, 482 U.S. 137, 146 (1987); 20 C.F.R. §§ 404.1512(c), 404.1521(a) (2004). An impairment is severe only if it significantly limits a claimant's physical or mental abilities to perform basic work activities. See 20 C.F.R. §§ 404.1512(c), 404.1521(a) (2004). "An impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings, not only by your statement of symptoms." See 20 C.F.R. § 404.1508 (2004).

Although plaintiff has provided several medical records, none of these records contains a medical opinion which establishes that plaintiff had any severe impairment, including Chronic Fatigue Syndrome, prior to December 31, 1999, his last insured date. (Tr. 242-572.) The only relevant medical opinion in the record concludes that there was insufficient evidence to establish any severe impairment prior to December 31, 1999. (Tr. 16.) Additionally, the ALJ specifically reviewed plaintiff's records for the period at issue with respect to Chronic Fatigue Syndrome, and he found that the opinion of the state agency physician was consistent with the weight of the relevant medical evidence. (Tr. 14-16.) The lack of medical records constitutes substantial evidence which supports the ALJ's finding that plaintiff did not have a severe

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limitation prior to his date last insured. See Magallanes, 881 F.2d at 750. Accordingly, the undersigned finds that plaintiff has not established that he had a severe impairment prior to his date last insured.

IV. Conclusion

The undersigned finds that the ALJ's decision to deny plaintiff DIB benefits is supported by substantial evidence in the record and is based on proper legal standards. See Magallanes, 881 F.2d at 750. The ALJ's findings are rational and reasonable interpretations of the record. See Andrews, 53 F.3d at 1041. The ALJ properly evaluated the medical records in evidence. However, those records failed to establish that plaintiff had any severe impairment prior to his date last insured of December 31, 1999.

Accordingly, IT IS RECOMMENDED that:

1. Plaintiff's motion for summary judgment or remand be denied, and

2. The Commissioner's cross motion for summary judgment be granted.

These findings and recommendations are submitted to the United States District Judge assigned to the case, pursuant to the provisions of Title 28 U.S.C. § 636(b)(l). Within fifteen days after being served with these findings and recommendations, any party may file written objections with the court and serve a copy on all parties. Such a document should be captioned "Objections to Magistrate Judge's Findings and Recommendations." Any reply to the objections shall be served and filed within ten days after service of the objections. The parties are advised that failure to file objections within the specified time may waive the right to appeal the District Court's order. Martinez v. Ylst, 951 F.2d 1153 (9th Cir. 1991).

DATED: September 8, 2005.

CRAIG M. KELLISON
UNITED STATES MAGISTRATE JUDGE